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No. _____

In The
Supreme Court of the United States

JAY DOROSHOW,
Petitioner,

v.

HARTFORD LIFE AND ACCIDENT INSURANCE CO.,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

PETITION FOR A WRIT OF CERTIORARI

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October 19, 2009

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QUESTION PRESENTED

In a 2 to 1 decision, a panel of the Third Circuit affirmed the district court's opinion that a physician's entry in an office note, "Was not thought to be ALS," constituted advice within the meaning of a disability insurance policy governed by the Employee Retirement Income Security Act, 29 U.S.C. §1001 et seq. ("ERISA"). The policy contained a pre-existing condition clause which precluded coverage for any condition for which medical advice or treatment was rendered during a three-month "look-back" period. The Third Circuit Court of Appeals denied a petition for rehearing en banc.

This case presents a sole question:

Whether, under ERISA, a negative diagnosis recorded in a physician's office note can be "advice" within the meaning of a pre-existing condition exclusion in a disability insurance policy?

CORPORATE DISCLOSURE STATEMENT

Jay Doroshow is an adult individual residing in the Commonwealth of Pennsylvania.

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OPINIONS BELOW

The decision of the United States Court of Appeals for the Third Circuit is reported at ___ F.3d ___, 2009 U.S.App.LEXIS 16820 and is reproduced in the Appendix herein at 1a – 18a. The Third Circuit issued an amendment of the opinion reported at ___ F.3d ___, 2009 U.S.App.LEXIS 17010, and the amendment is incorporated in the decision in the Appendix herein at 1a – 18a. The decision of the U.S. District Court for the Eastern District of Pennsylvania is reported at 560 F.Supp.2d 392, 2008 U.S.Dist.LEXIS 42796 and is reproduced in the Appendix at 19a – 37a.

JURISDICTION

The judgment of the Third Circuit Court of Appeals was issued July 30, 2009. Pet. App. 1a. Petitioner's timely petition for rehearing and rehearing en banc was denied by a 6 to 3 vote on August 25, 2009, Pet. App. 38a. This Court's jurisdiction is invoked under 28 U.S.C. 1254(1).

STATUTORY PROVISION INVOLVED

Title 29 United States Code, Section 1132(a)(1)(B)

§1132. Civil Enforcement

(a) Persons empowered to bring a civil action. A civil action may be brought –

(1) by a participant or beneficiary –

* * *

> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;
>
> * * *

STATEMENT OF THE CASE

1. In this case, petitioner Jay Doroshow contends that a negative diagnosis cannot be deemed advice for the purpose of invoking a pre-existing condition exclusion under a disability insurance policy. Construing a negative diagnosis as advice will enable insurers to greatly expand pre-existing condition exclusions and unjustifiably deny benefits to a broader base of applicants. This is an issue of first impression and dissension among the judges of the Third Circuit is indicative of the need for guidance from this Court.

Jay Doroshow was employed as a pharmacist by CVS Corporation from March 19, 2006, until March 29, 2007. Hartford is the insurer for the CVS Corporation Long Term Disability Income Insurance Plan, a group employee benefit plan (hereinafter the "Plan") formed in accordance with the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001 et seq., and administered by CVS Corporation. The Plan is insured through a policy issued by Hartford bearing Group Policy No. 83130668. Under the Plan, Hartford performs ministerial functions, including determination of eligibility for benefits.

As an employee of CVS, Mr. Doroshow enrolled in the Plan effective July 1, 2006. On March 15, 2007, a

neurologist, Dr. Leo McCluskey, diagnosed Mr. Doroshow with Amyotrophic Lateral Sclerosis (also known as "ALS" or "Lou Gehrig's Disease"). ALS is an incurable, insidious and progressive disease that results in loss of muscle function and, eventually, death. Mr. Doroshow took a medical leave of absence on March 29, 2007. Because of the degenerative nature of this disease, Mr. Doroshow will never recover and will ultimately succumb from muscle failure of vital organs.

Mr. Doroshow applied for long term-disability benefits from the aforementioned plan. Hartford denied Mr. Doroshow's claim citing its "Preexisting Condition" exclusion as the reason for the denial. Hartford's policy defines a preexisting condition as "a condition for which medical treatment or advice was rendered, prescribed or recommended within 12 months (3 months for exempt employees) prior to your effective date of insurance." Hartford relied on a single office note from Mr. Doroshow's family physician, Dr. Arnold Goldstein, dated May 16, 2006. That note reads "motor neuron disease. lumbosacral plexitis is the most recent diagnosis. **Was not felt to be ALS**." (emphasis added). Based solely upon Dr. Goldstein's office note, Hartford determined Mr. Doroshow received "treatment or advice" for ALS within three months prior to the effective date of his insurance coverage. Mr. Doroshow appealed the denial of benefits on September 14, 2007. In a letter dated December 13, 2007, Hartford upheld the denial of benefits, again citing only Dr. Goldstein's office note as "treatment or advice" for ALS rendered during the policy's look-back period.

2. On January 15, 2008, Jay Doroshow filed a complaint against Hartford, the insurer for his employer's Long Term Disability Income Insurance Plan pursuant to the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001 et seq. Both parties filed cross-motions for summary judgment. On May 30, 2008, the Honorable Robert F. Kelly, Sr. granted Hartford's' motion for summary judgment and denied the petitioner's motion for summary judgment.

3. On June 22, 2008, Mr. Doroshow filed a timely appeal to the Third Circuit. An expedited oral argument took place on February 3, 2009. On July 30, 2009, a three-judge panel affirmed the district court opinion with Judges Jordan and Roth issuing the majority opinion and Judge Rendell dissenting. Petitioner filed a timely Petition for Panel Rehearing with Suggestion for Rehearing En Banc. In a 6 to 3 vote, the Third Circuit denied the Petition for Rehearing on August 25, 2009. Pet. App. 38a.

REASONS FOR GRANTING THE WRIT

A. AN IMPORTANT FEDERAL QUESTION EXISTS REGARDING WHETHER A NEGATIVE DIAGNOSIS CAN CONSTITUTE ADVICE UNDER A POLICY GOVERNED BY ERISA.

ERISA's standards and procedural protections partly reflect a congressional determination that the common law of trusts did not offer completely satisfactory protection to persons enrolled in employee benefit plans. Varity v. Howe, 516 U.S. 489, 116 S.Ct. 1065, 134 L.Ed.2d 130 (1996). Even with respect to the trust-like fiduciary standards ERISA imposes,

Congress expected that the courts will interpret the prudent man rule bearing in mind the special nature and purpose of employee benefit plans as they develop a federal common law of rights and obligations under ERISA-regulated plans. Id. In the present case, petitioner contends that the Supreme Court's instruction is necessary to establish a common sense definition for "advice" in ERISA-regulated plans and prevent insurers from so broadly construing pre-existing condition exclusions to encompass any condition a physician may have remotely considered.

1. **Standard of Review.**

Petitioner acknowledges that Hartford's interpretation of the term "advice" in the policy must be reviewed under a deferential arbitrary and capricious standard. Metropolitan Life Insurance Company v. Glenn, 128 S. Ct. 2343 (2008). However, petitioner contends it is never reasonable to construe a negative diagnosis as advice.

2. **Ruling Out a Disease in a Progress Note is Not Advice.**

The Third Circuit has created a brand new pitfall in ERISA litigation. An insured must now fear that a differential diagnosis expressed by his/her physician in an office note he/she was not even aware of may result in the denial of disability benefits.

The root of this dispute is the parties' interpretation of the word "advice." Pet. App. 9a. Since the term is not defined in Hartford's policy, it must be given its ordinary meaning. The lower courts used the *Random House College Dictionary* to define "advice" as

an "opinion or recommendation offered as a guide to action." Pet. App. 9a-10a.

This appeal turns on the writing in Dr. Goldstein's office note of May 16, 2006. Court of Appeals Appendix, ("A") 71 – 72. The note in question was not written to anyone. The first part of the note simply records the plaintiff's weight and vital signs. A-71 and 72. Under "Assessment," Dr. Goldstein first noted the "CVA" [stroke] which he was following the plaintiff for. A-71 and 72. Secondly, he noted the presence of a motor neuron disease most recently diagnosed as lumbosacral plexitis. A-71 and 72. Then he added the infamous words " Was not felt to be ALS." A-71 and 72. Following that statement were recitations of laboratory results and MRI findings, **all factual information.** A-71 and 72. Dr. Goldstein noted his findings upon physical examination. "Good strength. Mild tremor . . ." Then comes Dr. Goldstein's advice. "PLAN: Continue all meds." A-71 and 72.

The entry " Was not felt to be ALS" was simply Dr. Goldstein's thought recorded in his office note. The note does not reflect that the comment was offered to anyone, let alone to Mr. Doroshow as a guide to action. A-71 and 72. "Was not felt to be ALS" is no more a guide to action than "blood pressure is 143/74" or "triglycerides are 94." The note also does not tell us the basis for Dr. Goldstein's belief that Mr. Doroshow's condition "was not felt to be ALS." It is simply a recorded thought.

Whether ruling out a disease or condition is medical advice appears to be an issue of first impression. Indeed, petitioner's research found only one court which has addressed the issue. In Cohen v.

Metropolitan Life Insurance Co., 485 F.Supp.2d 339 (S.D.N.Y. 2007), the Southern District of New York held that the insurer's preexisting condition exclusion **did not apply as a matter of law** even though the plaintiff's primary care physician "ruled out" chronic fatigue syndrome as a diagnosis during the look-back period. Id. at 352-354.

In Cohen, the MetLife policy provided an exclusion from coverage for a disability "caused by, contributed to, or resulting from a Pre-existing Condition." Id. at 342. The policy defined "Pre-existing Condition" as "a Sickness or Injury for which [the participant] received Medical Advice or Treatment during the 3 month period immediately prior to [the participant's] effective date . . ." Id.[1] Unlike the Hartford policy, MetLife's policy further defined "Medical Advice or Treatment" to include medical treatment or consultation. Id. at 343.

Ms. Cohen applied for disability benefits on March 18, 1997. Id. at 343. Her application listed Chronic Fatigue Syndrome (CFS) as the disabling condition and also gave a number of symptoms, including muscle pain and motor control problems, as conditions that prevented her from performing the duties of her employment. Id. She identified the date of onset of her disability as December 11, 2006, the day after her last

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[1] Compare with the very similar Hartford policy language which excludes "any loss caused by, contributed to, or resulting from a "Pre-existing Condition" and defines "Pre-existing Condition" as "a condition for which medical treatment or advice was rendered, prescribed or recommended within 12 months (3 months for exempt employees) prior to Your effective date of insurance." A-46 and 47.

day of work. Id. Since Ms. Cohen was a participant in a prior disability plan, there were actually two effective dates of coverage and two overlapping look-back periods that extended from March 21, 1996, through July 31, 1996. Id. at 342-343. During this time period, Ms. Cohen saw her primary care physician on April 29, 1996. He referred her for further evaluation by a neurologist. Ms. Cohen saw the neurologist on June 19, 1996 and July 17, 1996. Id. at 345. MetLife relied on these **three office visits** to deny her claim for benefits based on the policy's preexisting condition exclusion. Id.

As part of the internal appeal, Ms. Cohen's counsel provided to MetLife a typewritten transcription of the primary care physician's office notes and a letter from the physician which stated:

> I consulted with Dr. Belok [the neurologist] **at that time** and Chronic Fatigue Syndrome **was considered and ruled out as a diagnosis**. I am familiar with Chronic Fatigue Syndrome, however, there was insufficient basis for such a diagnosis **at that time** (emphasis added). Id. at 345.

Despite the doctor's letter, MetLife refused to reverse its denial of benefits. In its final determination letter, MetLife again noted the same visits for complaints of chronic tiredness, headaches, dizzy spells and disequilibrium, double vision, gait disturbance, and misplacing objects with her hands. Id. at 346. MetLife also relied on letters from other physicians dated outside the look-back period which commented that the CFS with off-balance type of feeling started as much as 2 ½ years earlier. Id. Because Ms. Cohen

sought medical advice and treatment during the look-back period for many of the same symptoms she later claimed were associated with CFS and which prevented her from working, MetLife concluded that Ms. Cohen indeed must have suffered from CFS during the look-back period even though her doctors ruled it out. Id. at 347. MetLife did not consult with any outside experts before reaching its conclusion. Id. Interestingly, MetLife did not make the argument that Hartford advances here, that even a negative finding constitutes "advice" for the purposes of invoking the preexisting condition exclusion.

The District Court ruled that MetLife's decision failed even under the more deferential arbitrary and capricious standard of review. Id. at 349. It noted the sponsor of a plan has the burden of demonstrating the applicability of a coverage exclusion. Id. MetLife misconstrued the policy's terms and made assumptions unsupported by the administrative record. Id. The court held that the plan dictated an insured must suffer from the condition causing or contributing to the later diagnosed disability during the look-back period. Id. at 350. In the absence of a specific diagnostic basis to conclude a disease is present, merely receiving advice or treatment for similar non-specific symptoms of a later diagnosed condition is not sufficient to preclude coverage. Id. The court concluded:

> Thus, none of the contemporaneous documentation of Medical Advice or Treatment relied upon by MetLife in connection with the look-back period establishes a relevant diagnosis or any medical basis for finding a causal, or even contributory, relationship between the symptoms for which Cohen was

> examined or treated and the Disability that she claimed in March 1997. All that it demonstrates is that Cohen had some symptoms that were similar in kind to those she claimed had disabled her beginning in December 1996. **Furthermore, the only diagnostic opinion in the record speaking to the question of whether Cohen suffered from CFS during the relevant period is negative.** (emphasis added). Id. at 352.

If, as in the Cohen opinion, an insurer acts arbitrarily and capriciously when it dismisses a negative diagnosis, then an insurer certainly cannot reasonably rely on a negative diagnosis as "advice" guiding a course of action to preclude coverage.

In the present case, Mr. Doroshow had only one doctor visit during the look-back period. A-71 and 72. Unlike in Cohen, there wasn't even a discussion among doctors here, just Dr. Goldstein's recorded thought "Was not felt to be ALS" perhaps based on a review of earlier records in the chart. The majority of the Third Circuit panel erroneously concluded that it was reasonable for Hartford to construe "Was not thought to be ALS" as advice based simply on the fact that the petitioner had been worked up for ALS in 2005 at which time it was ruled out. Doing so has now opened the door for insurers to broadly expand pre-existing condition exclusions to include diseases or conditions an insured may have never had simply because of their inclusion in a differential diagnosis the insurer construes as "advice."

3. Advice Must be Given to Someone

In the District Court opinion, Judge Kelly commented that a negative diagnosis was advice because "Ruling out ALS meant that **Dr. Goldstein would treat** Doroshow's motor neuron disease differently" and "Dr. Goldstein rendered an opinion that dictated the course of action **he would take**. . ." (emphasis added) Pet. App. 32a. The very nature of advice is that it is offered to someone else to guide the other person's actions. Judge Kelly's ruling effectively holds that the "advice" Dr. Goldstein gave when he wrote "Was not felt to be ALS" in his progress note was to himself. Taken to the extreme, any writing in any medical record could then be construed as "advice." Laboratory results, for example, may be reviewed again by the ordering physician or a specialist and relied upon when deciding upon a particular course of treatment. While perhaps broader than treatment, the concept of "advice" cannot be that broad.

Haley v. The Paul Revere Life Insurance Co., 77 F.3d 84 (4th Cir. 1996) is illustrative of what advice should be. Mr. Haley became disabled in February 1990 due to ankylosing spondylitis (a fusing of the spine) and neuropathies (a degeneration of the nerves). Id. at 85. The insurer denied the claim based on a preexisting condition exclusion. At issue was a June 1989 visit during the look-back period. **The Court noted that Mr. Haley's prior medical records documented him having ankylosing spondylitis before the look-back period** although it was stable. Id. at 86-87. On June 21, 1989, **Mr. Haley returned to his doctor specifically for that condition**. Id. Though Mr. Haley argued he went to the doctor simply to refill several prescriptions, the Court noted he

nevertheless conversed with the doctor regarding his spondylitis. Id. at 90. At his deposition, Mr. Haley testified he "wanted his money's worth" from the visit. Id. at 90.

In the present case, no insured would expect a doctor's thought or opinion recorded in an office note and not offered to anyone in particular to constitute advice. It is simply not reasonable to construe a disability insurance policy in such a way as to render a ruling out of a disease "advice" and deprive an insured of benefits to which he would otherwise be entitled.

In this case, Judge Kelly and a majority of the Third Circuit panel erroneously concluded that Hartford was reasonable in construing "Was not thought to be ALS" as advice simply because the petitioner was evaluated for the disease in 2005, though it was ruled out at that time. They failed to focus solely on the look-back period as required by the language of the Hartford policy. Under the policy, a person actually diagnosed with a condition may avoid the pre-existing condition exclusion and receive benefits as long as he or she does not receive treatment or advice during the applicable time frame. Congress certainly could not have intended a person with a disease, but who fortuitously avoids treatment, to receive benefits while a person who is told during the look-back period he does not have the disease is denied benefits because he received "advice."

B. THE THIRD CIRCUIT IS DIVIDED IN THE APPLICATION OF ITS OWN PRECEDENT.

The Honorable Judge Rendell succinctly summarized the majority opinion's flaws in her dissent:

> "Jay Doroshow is entitled to benefits because he was neither given advice nor treated *for* ALS, prior to his diagnosis of that condition in March 2007—nearly one year after his doctor not only diagnosed him with a *different* condition but had actually *rejected* a diagnosis of ALS. The majority's conclusion that his doctor's *negative* diagnosis of ALS during the relevant three-month period somehow renders his later-diagnosed ALS a 'pre-existing condition' under Hartford's policy rests upon a seriously flawed reading – or total disregard – of the definition of this phrase provided in the Hartford policy, as well as two precedents of our court construing similar policy terms. *McLeod v. Hartford Life & Acc. Inc. Co.*, 372 F.3d 618 (3d Cir. 2004); *Lawson ex rel. Lawson v. Fortis Ins. Co.*, 301 F. 3d 159 (3d Cir. 2002)." (emphasis in original). Pet. App. 14a.

The Third Circuit has previously held that the definition of "for" in regard to treatment for a pre-existing condition requires an intent that the treatment or advice be directed to the specific condition which the insurer relies on to exclude benefits. In McLeod v. Hartford Life and Accident Insurance Company, 372 F.3d 618 (3rd Cir. 2004), Hartford denied the plaintiff disability benefits because it claimed she received treatment for multiple

sclerosis during the "look back" period. On February 22, 1999, the plaintiff sought treatment for numbness of her left arm. Id. at 621. Six months later, Ms. McLeod was diagnosed with MS. Id.

With the benefit of hindsight, the plaintiff's treating physician in McLeod attributed various pre-coverage symptoms to MS and even noted in her application for disability benefits that the date of onset of the condition was 1997, two years earlier. Id. at 622. Hartford relied on the onset date to deny coverage. Yet, unlike the present case, Hartford also forwarded Ms. McLeod's file for an independent medical review. Not surprisingly, the reviewer concluded Ms. McLeod had MS during the look-back period.

The Third Circuit held that "considering treatment for symptoms of a not-yet diagnosed condition as equivalent to treatment of an underlying condition ultimately diagnosed might open the door for insurance companies to deny coverage for any condition, the symptoms of which were treated during the exclusionary period." Id. at 628. The Third Circuit further stated, when defining what constitutes receiving treatment "for" a condition, the word "for" itself must, by definition, include a notion of intentionality. Id. at 625. Harkening back to its decision in Lawson ex rel. Lawson v. Fortis Insurance Co., 301 F.3d 159 (3rd Cir. 2002), the Third Circuit again emphasized that one cannot receive treatment for a condition when neither the patient nor the doctors know what the condition is. Id at 625.

Here, the panel majority distinguished Mr. Doroshow's case from McLeod by reference to a 2005 work-up for his symptoms in which two physicians,

including Dr. McCluskey, considered ALS as part of a differential diagnosis. Instead of noting that Dr. McCluskey ruled out ALS at that time and the absence of any ongoing testing or follow up for ALS until March 2007, the panel majority chose instead to emphasize the fact that ALS had, at one time, been considered. They concluded that the mere fact ALS had once been considered made it reasonable for Hartford to construe Dr. Goldstein's note as "advice" regarding ALS. Pet. App. 11a. Astonishingly, the majority wrote "Based on his family history of ALS and his medical records, we conclude that it is clear Doroshow sought advice for ALS when he visited Dr. Goldstein during the look-back period." Pet. App. 13a.

In her dissent, Judge Rendell observed that the majority's conclusion "requires wholesale revision on Dr. Goldstein's note of May 16, 2006 – the *only* evidence of diagnosis, treatment or advice during the look-back period." Pet. App. 17a. Dr. Goldstein's note reflects follow up for a stroke. A-71 and 72. The motor neuron disease was believed to be lumbosacral plexitis. Where is the "opinion or recommendation offered as a guide to action" with regard to ALS?[2] On May 16, 2006, no one, including Dr. Goldstein, still suspected ALS. Mr. Doroshow's doctors were not actively seeking, through diagnostic testing or otherwise, to determine whether his leg weakness was related to ALS. A-71 and 72. Mr. Doroshow's records do not reflect any intentionality on the part of his treating

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[2] The courts accepted the Random House College Dictionary definition of the word "advice." Yet, the panel majority fails to explain how Dr. Goldstein intended "Was not felt to be ALS" as a guide for action for Mr. Doroshow regarding ALS.

physicians to treat ALS. On the contrary, prior to March 15, 2007, they believed it was a lumbosacral plexitis or a polyneuropathy. A-71 to 78.

In Lawson, supra, this Court stated "...it is hard to see how a doctor can provide treatment 'for' a condition without knowing what that condition is or that it even exists." Id. at 166. The same should hold for advice, if given. In the present case, neither Mr. Doroshow nor Dr. Goldstein intended or thought that the office visit on May 16, 2006, was for ALS. On the contrary, Dr. Goldstein specifically wrote **"Was not felt to be ALS."** The diagnosis of lumbosacral plexitis did not change until Dr. McCluskey performed the EMG on March 15, 2007. A-80.

The disability policy language in McLeod was also far broader than the language in Mr. Doroshow's policy. It read in pertinent part:

> Pre-existing condition is one in which...(2) any manifestations, symptoms, findings or aggravations related to or resulting from such accidental bodily injury, sickness, mental illness, pregnancy or substance abuse; for which you received medical care during the 90 day period that ends the day before: (1) your effective date of coverage. Id. at 625-626.

The McLeod policy further provided "medical care is received when (1) a physician is consulted or medical advice is given; or (2) treatment is recommended, prescribed by, or received from a physician." Id. at 626. Nevertheless, the Third Circuit held Hartford was using an "ex post facto analysis" that would mean "a whole host of symptoms occurring before a 'correct'

diagnosis is rendered, or even suspected, can presumably be tied to the condition once it has been diagnosed." The Third Circuit concluded:

> Seeking medical care for a symptom of a pre-existing condition can only serve as the basis for exclusion from receiving benefits in a situation where there is some intention on the part of the physician or of the patient to treat or uncover the underlying condition which is causing the symptom. Id. at 628.

In Ceccanecchio v. Continental Casualty Co., 50 Fed. Appx. 66, 70, 2002 U.S.App. LEXIS 21496 (3rd Cir. 2002), the Third Circuit continued the precedent of Lawson and McLeod. The plaintiff was also a pharmacist denied long term disability benefits based on a preexisting condition clause. Continental's exclusionary policy was not materially different from Hartford's. Within the six-month exclusionary period applicable to Ceccanecchio, her gynecologist noted during a routine exam problems of "urinary frequency and urgency and also nocturia times four for the past year." Id. at 67. The doctor's note did not include any diagnosis, nor did he render, prescribe or recommend any treatment, medication or further testing for any specific condition. Later, Ceccanecchio was diagnosed with interstitial cystitis, a condition of the bladder occurring predominantly in women, which often causes urinary frequency and pain on bladder filling at the end of micturition. Id. at 68. Just like Hartford in the present case, Continental denied Ceccanecchio's claim based solely on the earlier doctor's office note. Continental argued because Ceccanecchio experienced similar symptoms in April 1997 for the condition which she was eventually diagnosed with in August

1997, it was "self-evident" she had the same condition in April during the exclusionary period. Id. at 71.

The district court overturned Continental's denial and awarded Ceccanecchio benefits. The Third Circuit affirmed on appeal and stated the "similarity of symptoms alone is not enough to prove that she had a preexisting condition because the symptoms she complained of in April were non-specific. [Ceccanecchio] asserts, without contradiction, that any number of underlying conditions could have caused her symptoms." Id. at 71. This Court concluded that invoking the pre-existing condition exclusion was arbitrary and capricious:

> [Continental's] decision is not supported by, and is indeed traversed by, competent evidence. It may have been "self-evident" to the inexpert administrator/insurer that Ceccanecchio suffered from interstitial cystitis in April. But it was not evident, much less "self-evident," to her urologist, Dr. Hanno, who formed his opinion after treating her for three months. His informed, expert opinion, and decisive for us, bears repeating: "It is unclear whether [sic] her symptoms of interstitial cystitis began. Her diagnosis was not made until August of 1997 and with a disease like this which is manifested by an exaggeration of normal behavior and normal sensation, one cannot say for certain which date it began." Id. at 71-72.

To interpret the Hartford policy as the panel majority has done, is to disregard the precedents of Lawson and McLeod and expand the definition of a "preexisting condition" in a disability policy to any

disease or condition that may at one time have been considered, even though it was ruled out. Allowing the Third Circuit's opinion in this case to stand will result in many more insureds losing their benefits based on insurers interpreting pre-existing condition exclusions to include anything contained in a differential diagnosis even if later ruled out.

CONCLUSION

For the reasons set forth herein, petitioner respectfully requests this Honorable Court to grant a writ of certiorari.

Respectfully Submitted,

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APPENDIX

APPENDIX A

PRECEDENTIAL

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 08-2836

[Filed July 30, 2009]
[As Amended July 30, 2009]

JAY DOROSHOW,

Appellant.

v.

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

On Appeal from the United State District Court
for the Eastern District of Pennsylvania
(D. C. 2-08-cv-00259)
District Judge: Hon. Robert F. Kelly

Argued on February 3, 2009

Before: RENDELL, JORDAN and ROTH, Circuit Judges

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OPINION

ROTH, Circuit Judge:

Jay Doroshow appeals the District Court order granting summary judgment in favor of Hartford Life and Accident Insurance Company. The District Court found that Hartford had not been arbitrary and capricious in its decision to deny long term disability benefits to Doroshow under an employee welfare benefit plan, governed by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C.

§ 1001, et seq. For the following reasons, we will affirm that decision.

I. Background

Doroshow was an employee of the CVS Corporation and participated in its Long Term Disability Income Insurance Plan, a group benefit plan issued by Hartford. CVS "delegated sole discretionary authority to Hartford ... to determine [the participant's] eligibility for benefits and to interpret the terms and provisions of the plan and any policy issued in connection with it."

Doroshow's effective date of coverage was July 1, 2006. Under the plan, long term disability benefits are not payable for disabilities "caused by, contributed to, or resulting from ... a preexisting condition." A pre-existing condition is one "for which medical treatment or advice was rendered, prescribed or recommended within 12 months (3 months for exempt employees) prior to [the participant's] effective date of insurance." It is undisputed that Doroshow was subject to the three-month look-back period.

Doroshow was diagnosed definitively with Amyotropic Lateral Sclerosis (ALS) on March 15, 2007. On March 16, 2007, Doroshow applied for disability benefits under the Hartford plan. Hartford denied Doroshow's claim on August 30, 2007, writing:

> Our review of all of the medical information in your claim file shows that you are claiming benefits because of symptoms related to motor neuron disease (MND), which includes amyotrophic lateral sclerosis (ALS). The

> medical records obtained from the office of Dr. Goldstein indicate that you were treated for this condition on 05/16/2006. ALS was discussed in this OV, likely due to the type of symptoms you were experiencing and the family history of this disease. Intermittent workup and follow up continued for your reported symptoms until definitive diagnosis was reached in March 2007. You were provided advice related to the possibility of an ALS diagnosis on 05/16/2006, and the symptoms were certainly a precursor to the eventual diagnosis of ALS. This treatment date falls within the 3 month period that ends before your effective date of LTD coverage. This information shows that your condition was Pre-existing.

The office visit with Dr. Arnold Goldstein, M.D., Doroshow's primary care physician, to which Hartford referred in its denial letter, occurred on May 16, 2006, during the look-back period. Hartford's denial relied on Dr. Goldstein's office notes, in which he wrote, "Motor neuron disease. Lumbrosacral plexitis is the most recent diagnosis. Was not felt to be ALS." Hartford determined that during this office visit Dr. Goldstein had rendered advice pertaining to ALS, thus making Doroshow ineligible for long-term disability benefits under the pre-existing condition plan exclusion.

Even prior to the Dr. Goldstein visit during the look-back period, Doroshow's medical records indicate he had received advice and undergone testing related to ALS based on symptoms he was experiencing and a family history of the disease. On July 25, 2005, Dr. Mark J. Brown, M.D., a neurologist, conducted an electromyographic (EMG) test on Doroshow. In Dr.

Brown's notes, he wrote: "1. Chronic active degeneration of right leg, arm, paraspinal and bulbar muscles with near-normal nerve conduction studies. These are features of a motor neuron disease. 2. If the left Babinksi sign is a consistent feature then he has the ALS form of motor neuron disease."

Following this test, Doroshow visited Leo McCluskey, M.D., an ALS specialist, on July 27, 2005. Dr. McCluskey wrote that "Doroshow demonstrates evidence of a lower motor neuron process affecting his right leg" and that "[h]e has no upper motor neuron signs." Accordingly, Dr. McCluskey felt that "[t]hese are features that do not support the diagnosis of amyotropic lateral sclerosis or a progressive motor neuron disorder." Doroshow was under Dr. McCluskey's treatment for motor neuron disease between April 1, 2000, and June 30, 2006. Dr. McCluskey was ultimately the doctor who diagnosed Doroshow with ALS on May 15, 2007.

After he unsuccessfully appealed Hartford's decision via its internal administrative procedures, Doroshow filed an action in the District Court pursuant to 29 U.S.C. § 1132(a)(1)(B). He claimed that Hartford's denial was arbitrary and capricious. Both parties subsequently filed motions for summary judgment. The District Court determined that Doroshow had not demonstrated that Hartford's decision was arbitrary and capricious and granted judgment for Hartford. Doroshow appealed.

II. Standard of Review

We have jurisdiction over this appeal under 28 U.S.C. § 1291 and exercise plenary review over the

District Court's decision to grant summary judgment. Summary judgment is appropriate when the "pleadings, the discovery and disclosure materials on file, and any affidavits show that there is no genuine issue as to any material fact and that the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c).

III. Discussion

Before addressing the merits of Doroshow's appeal, we must first determine what standard of review a trial court must apply in 29 U.S.C. § 1132(a)(1)(B) actions. In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the Supreme Court held that "a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.* at 115. When the administrator has discretionary authority to determine eligibility for benefits, as Hartford did in this case, the decision must be reviewed under an arbitrary and capricious standard. Under that standard, "if a benefit plan gives discretion to an administrator or a fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Id.*

Until recently, this Circuit had used a sliding scale approach to address conflicts of interest and their impact on the amount of discretion that should be afforded to the decisions of plan administrators. *See Estate of Schwing v. The Lilly Health Plan*, 562 F.3d 522, 525 (3rd Cir. 2009). Under the sliding scale approach, "if the level of conflict is slight, most of the

administrator's deference remains intact, and the court applies something similar to traditional arbitrary and capricious review; conversely, if the level of conflict is high, then most of its discretion is stripped away." *Post v. Harford Ins. Co.*, 501 F.3d 154, 161 (3d Cir. 2007). In *Pinto v. Reliance Std. Life Ins. Co.*, 214 F.3d 377 (3d Cir. 2000), we said, "an insurance company [that] both funds and administers benefits ... is generally acting under a conflict that warrants a heightened form of the arbitrary and capricious standard of review." *Id.* at 378. Under the heightened version of this form of review, a court should be "deferential, but not absolutely deferential" to the administrator. *Id.* at 393. The District Court, following *Pinto*, used a heightened arbitrary and capricious standard to review Hartford's rejection of Doroshow's claim for benefits because Hartford both funded the plan and was solely responsible for determining eligibility under the plan.

In making its determination, the District Court did not have the benefit of *Metropolitan Life Ins. Co. v. Glenn*, 128 S.Ct. 2343 (2008), in which the Supreme Court rejected a conflict of interest review that requires a heightened arbitrary and capricious standard. In *Glenn*, a participant in a long-term disability insurance plan administered by Metropolitan Life Insurance Company (MetLife) challenged MetLife's determination that she was no longer eligible for benefits because she was not totally disabled. MetLife both funded the plan and had discretionary authority to determine the validity of an employee's benefits claim, creating the same type of conflict of interest that we found in *Pinto* and that we have in this case.

With *Glenn*, the Court aimed to elucidate its previous precedent in *Firestone* that a conflict should be weighed as a factor in determining whether there is an abuse of discretion. *Glenn*, 128 S.Ct. at 2350. In doing so, the Court emphasized that the existence of a conflict did not change the standard of review from abuse of discretion to a more searching review. *Id.* at 2351. The Court explained that any one factor could act as a tiebreaker when the other factors are closely balanced. The greater "the tiebreaking factor's inherent or case-specific importance[,]" the less closely the other factors must be balanced for that tiebreaking factor to be decisive. *Glenn*, 128 S. Ct. at 2351. The Court provided an example:

> The conflict of interest at issue here, for example, should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affected the benefits decision, including, but not limited to, cases where an insurance company administrator has a history of biased claims administration.... It should prove less important (perhaps to the vanishing point) where the administrator has taken active steps to reduce potential bias and to promote accuracy, for example, by walling off claims administrators from those interested in firm finances, or by imposing management checks that penalize inaccurate decisionmaking irrespective of whom the inaccuracy benefits.

Id.

The Court in *Glenn* reiterated its position in *Firestone* that a reviewing court should consider the

conflict of interest – but only as one consideration among many. *Id.* Insofar as *Glenn* implicitly overrules and conflicts with our precedent, requiring courts to apply a *heightened* arbitrary and capricious review, we will apply the *Glenn* abuse of discretion standard where a conflict of interest exists.

Next we turn to the merits of Doroshow's appeal in the context of *Glenn*.[1] Under a traditional arbitrary and capricious review, a court can overturn the decision of the plan administrator only if it is without reason, unsupported by substantial evidence or erroneous as a matter of law. *See Abnathya v. Hoffmann-La Roche, Inc.*, 2 F.3d 40, 45 (3d Cir. 1993). The scope of this review is narrow, and "the court is not free to substitute its own judgment for that of the defendants in determining eligibility for plan benefits." *Id.* (internal quotation marks omitted).

The parties' dispute centers around Hartford's interpretation of the word "advice" in the insurance contract, which defines a pre-existing condition as "a condition for which medical treatment or advice was rendered, prescribed or recommended within 12 months (3 months for exempt employees) prior to *Your* effective date of insurance." Because the contract provided no definition of advice, the District Court turned to the ordinary meaning of the term, "an opinion or recommendation offered as a guide to

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[1] Because the District Court applied the heightened review standard, which was more favorable to Doroshow than the new standard, we find no prejudice in our considering Doroshow's appeal using the *Glenn* standard without remanding.

action." *The Random House College Dictionary* 20 (Laurence Urdang et al. eds., 1973).

Using this definition, the District Court determined that Hartford was reasonable in finding that Doroshow received advice regarding ALS during the look-back period . Hartford, in rejecting Doroshow's claim, pointed to the notes of Dr. Goldstein from an office visit Doroshow had on May 16, 2006, in which Dr. Goldstein wrote, "Motor neuron disease. Lumbrosacral plexitis is the most recent diagnosis. Was not felt to be ALS." The District Court wrote:

> By stating his opinion that the motor neuron disease afflicting his patient was not ALS but rather lumbrosacral plexitis, Dr. Goldstein rendered an opinion about ALS during the three months prior to the effective date of coverage. Advice is a broader concept than treatment, and a doctor's conclusion that a patient is not suffering from a certain condition constitutes an opinion or recommendation offered as a guide to action.

Doroshow v. Hartford Life & Acc. Ins. Co., 560 F. Supp. 2d 392, 400 (E.D. Pa. 2008).

Though we do not find generally that ruling out a condition constitutes advice or treatment for that condition, we find Dr. Goldstein's notes related to ALS particularly compelling in the broader context of Doroshow's entire medical history. As early as 2005, ALS was considered as a possible diagnosis for the range of symptoms Doroshow had experienced. Dr. Brown noted that an EMG performed on Doroshow showed signs of a motor neuron disease and possibly

ALS. As a result of this test, and Doroshow's family history of ALS, Dr. Brown suggested Doroshow see an ALS specialist. This specialist, Dr. McClusky, found signs of a motor neuron disease but did not diagnose Doroshow with ALS. Because two doctors before Dr. Goldstein considered ALS as, at least, a possible explanation for his symptoms, we find Hartford's determination that Doroshow received advice pertaining to ALS specifically during the look-back period was reasonable.

We note, as the District Court did, that ALS is the most common form of motor neuron disease. Because of the inexorable, progressive nature of the disease, it is not surprising that, when Doroshow first began exhibiting symptoms, the doctors did not conclusively determine that he had ALS, but more generally said only that he had a form of motor neuron disease. From the record and Doroshow's family history of ALS, however, it seems that a diagnosis of ALS was repeatedly considered after he began showing symptoms of a motor neuron disease.

Doroshow, in support of his position that the "ruling out" of a condition cannot constitute advice, cites two of our cases, *McLeod v. Hartford Life & Acc. Ins. Co.*, 372 F.3d 618 (3d Cir. 2004), and *Lawson ex rel. Lawson v. Fortis Ins. Co.*, 301 F.3d 159 (3d Cir. 2002).[2] In *McLeod*, an employee was denied long-term disability benefits because of the alleged pre-existence of multiple sclerosis. He had sought treatment during

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[2] Doroshow cites a number of other cases that are not binding on this Court; we will not address those since they have no bearing on how we should rule in this case.

the look-back period for a variety of non-specific symptoms and was treated for a host of ailments, but during this period, neither the employee nor his doctors suspected multiple sclerosis. We found that Hartford's denial was arbitrary and capricious and held that seeking medical care for a symptom of a pre-existing condition can serve as a basis for denying coverage when there is some "intent to treat or uncover the particular ailment which causes that symptom (even absent a timely diagnosis), rather than some nebulous or unspecified medical problem." *McLeod*, 372 F.3d at 628.

In reaching this result in *McLeod*, we cited *Lawson*, in which we explained the difference between a "suspected condition without a confirmatory diagnosis" and "a misdiagnosis or an unsuspected condition manifesting nonspecific symptoms." *Lawson*, 301 F.3d at 166. We wrote:

> When a patient seeks advice for a sickness with a specific concern in mind (*e.g.* a thyroid lump, as in *McWilliams* [*v. Capital Telecomms. Inc.*, 986 F. Supp. 920 (M.D. Pa. 1997)], or a breast lump, as in *Bullwinkel* [*v. New England Mutual Life Ins. Co.*, 18 F.3d 429 (7th Cir. 1994)]) or when a physician recommends treatment with a specific concern in mind (*e.g.*, a "likely" case of multiple sclerosis, as in *Cury* [*v. Colonial Life Ins. Co. of Am.*, 737 F. Supp. 847 (E.D. Pa. 1990)]), it can be argued that an intent to seek or provide treatment or advice "for" a particular disease has been manifested. But when the patient exhibits only non-specific symptoms and neitherthe patient nor the physician has a particular concern in mind, or when the patient

> turns out not to have a suspected disease, it is awkward at best to suggest that the patient sought or received treatment for the disease because there is no connection between the treatment or advice received and the sickness.

Id. In *Lawson*, the patient was ultimately diagnosed with leukemia, but the insurance company based its denial of the benefits claim on an office visit during the look-back period in which the patient was treated for a respiratory tract infection. It was clear from the record that neither the patient's doctor or her parents ever considered leukemia as a possible diagnosis. Accordingly, we found the patient had not received medical advice or treatment for leukemia and could not be denied coverage because of a pre-existing condition. *Id.*

Doroshow suggests both *McLeod* and *Lawson* support his position that he had not received any advice related to ALS during the look-back period. The implication from his argument is that he falls into the category of "a misdiagnosis or an unsuspected condition manifesting non-specific symptoms," which under both *McLeod* and *Lawson* would not be demonstrative of a pre-existing condition. Contrary to Doroshow's claims, however, the record plainly demonstrates otherwise. Based on his family history of ALS and his medical records, we conclude that it is clear that Doroshow sought advice for ALS when he visited Dr. Goldstein during the look-back period. Therefore, he had a "suspected condition without a confirmatory diagnosis," which may appropriately be deemed a pre-existing condition.

IV. Conclusion

For the foregoing reasons, we will affirm the District Court's order granting Hartford's motion for summary judgment.

RENDELL, Circuit Judge - dissenting.

Jay Doroshow is entitled to benefits because he was neither given advice nor treated *for* ALS, prior to his diagnosis of that condition in March 2007 – nearly one year after his doctor had not only diagnosed him with a *different* condition but had actually *rejected* a diagnosis of ALS. The majority's conclusion that his doctor's *negative* diagnosis of ALS during the relevant three-month period somehow renders his later-diagnosed ALS a "pre-existing condition" under Hartford's policy rests upon a seriously flawed reading–or total disregard–of the definition of this phrase provided in the Hartford policy, as well as two precedents of our court construing similar policy terms. *McLeod v. Hartford Life & Acc. Ins. Co.*, 372 F.3d 618 (3d Cir. 2004); *Lawson ex rel. Lawson v. Fortis Ins. Co.*, 301 F.3d 159 (3d Cir. 2002).

Hartford's policy defines "pre-existing condition" as "a condition for which medical treatment or advice was rendered, prescribed, or recommended within 12 months (3 months for exempt employees) . . . prior to [the participant's] effective date of insurance." Critically, the policy does not say advice as to the *possibility* of ALS, as the Hartford Plan Administrator reasoned; advice *about* ALS, as the District Court loosely reasoned; or advice *relating* to or *pertaining* to ALS, as the majority seeks to paraphrase. Rather, determination of a pre-existing condition requires

provision of advice or treatment *for* that condition, here ALS, in April, May, or June 2006.[3]

Construing "for" as synonymous with "relating" or "pertaining" to, the majority disregards not one, but two, binding precedents of our court interpreting nearly identical policy language. In *Lawson*, Elena Lawson was diagnosed, and received treatment, for an upper respiratory tract infection. *Lawson*, 301 F.3d at 161. After her symptoms persisted, however, doctors diagnosed her with leukemia, and concluded that her earlier symptoms stemmed from that condition. Lawson's insurance policy defined "pre-existing condition" as a "Sickness, Injury, disease or physical condition for which medical advice or treatment was recommended by a Physician or received from a Physician . . . ." *Id.* Determining that Lawson's leukemia was a pre-existing condition, the insurer denied her claim. Reversing, the District concluded, "[I]n order to be treated for leukemia, there must have been some awareness that the disease existed at the time treatment or advice was rendered." *Id.* at 162. We affirmed, holding that the word "for" "connotes intent." *Id.* at 165. We reasoned–quite correctly–that "it is hard to see how a doctor can provide treatment 'for' a condition without knowing what that condition is . . . ." *Id.* Providing advice or treatment for the symptoms of a later-diagnosed condition, we emphasized, does not constitute treatment *for* that condition. In rejecting an expansive definition of "for," we explained:

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[3] The parties agree that the "pre-existing condition" from which Doroshow suffered was ALS.

> Although we base our decision on the language of the policy, we note that considering treatment for symptoms of a not-yet-diagnosed condition as equivalent to treatment of the underlying condition ultimately diagnosed might open the door for insurance companies to deny coverage for any condition the symptoms of which were treated during the exclusionary period. To permit such backward-looking reinterpretation of symptoms to support claims denials would so greatly expand the definition of preexisting condition as to make that term meaningless: any prior symptom not inconsistent with the ultimate diagnosis would provide a basis for denial.

Id. at 166 (internal citation omitted).

I submit that the majority here has fallen into this very trap by essentially concluding that, because Doroshow likely had ALS all along, ALS was a "pre-existing condition."[4] In so reasoning, the majority does a disservice to the policy language, to our precedent in *Lawson*, and to Doroshow himself.

In a subsequent opinion, *McLeod*, we went even farther than in *Lawson*, opining that policy language

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[4] The majority, indeed, focuses on Doroshow's medical history, including the initial suspicion of one of his doctors – *prior* to the three month look-back period – that Doroshow suffered from ALS. But Hartford's own definition of 'pre-existing' as it applies to Doroshow means during the three months before July 1, 2006. As discussed below, during that three-month period Doroshow's doctor rejected the ALS diagnosis in favor of a diagnosis of lumbosacral plexitis.

defining pre-existing condition as including *symptoms* for which the claimant received medical care also implied "some intention on the part of the physician or of the patient to treat or uncover the underlying condition which is causing the symptom." 372 F.3d at 628. As in *Lawson*, we distinguished a "suspected condition without a confirmatory diagnosis" and a "misdiagnosis." *Id.* at 628. Although the insurer in *McLeod* "placed great stock" in differences in its definition of pre-existing condition and that of the insurer in *Lawson*, we concluded that, when policy language requires that advice be "for" symptoms, "for" requires an "intent" to treat the symptoms of the *ultimately-diagnosed condition*. Accordingly, we reversed the District Court's determination that Hartford's denial of benefits was reasonable.

Today, the majority inexplicably casts these precedents aside, referring to their *dicta* without discussing their holdings. Instead, the majority concludes that Doroshow received advice for ALS, because ALS was a "suspected condition without a confirmatory diagnosis." However, to reach such a conclusion requires wholesale revision of Dr. Goldstein's note of May 16, 2006 - the *only* evidence of diagnosis, treatment, or advice during the look-back period. The note does not identify ALS as a suspected condition. To the contrary, Dr. Goldstein indicated, "Lumbosacral plexitis is the most recent diagnosis. Was not felt to be ALS." Doroshow did receive a "confirmatory diagnosis" and advice - not for ALS, but for lumbosacral plexitis.

Jay Doroshow is now suffering from ALS. It was not diagnosed until March 15, 2007 – ten months after his diagnosis of lumbosacral plexitis. Hartford's denial

of coverage based on its view that ALS was a pre-existing condition was arbitrary and capricious, not only because it contravened the definition of the term expressly provided in its policy, but also because this court has twice opined – indeed, once involving Hartford – that "for" connotes intent and is not synonymous with "related to" or "regarding."[5] Accordingly, I would reverse and remand for entry of an order requiring that benefits be paid to Jay Doroshow.

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[5] We have no difficulty concluding here, as we did in *McLeod*, that application of the "pre-existing condition" exclusion to Doroshow's *later-diagnosed* condition was arbitrary and capricious.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

CIVIL ACTION No. 08-259

[Filed May 30, 2008]

JAY DOROSHOW,
Plaintiff,

v.

HARTFORD LIFE AND ACCIDENT INSURANCE CO. and CVS CORPORATION LONG TERM DISABILITY INCOME INSURANCE PLAN
Defendants.

MEMORANDUM

ROBERT F. KELLY, Sr. J. **MAY 30, 2008**

This is an action to recover benefits under an employee welfare benefit plan, which is governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, et. seq. Presently before this Court are Cross-Motions for Summary Judgment. For the reasons stated below, the Plaintiff's Motion is denied, and the Defendant's Motion is granted.

I. BACKGROUND

Plaintiff Jay Doroshow ("Doroshow") was employed as a pharmacist at a CVS/pharmacy ("CVS") in Bensalem, Pennsylvania from March 19, 2006 through March 29, 2007. During this period of employment, he was eligible to participate in a disability insurance plan established by CVS for the benefit of its employees. This insurance plan provided Doroshow with an income benefit equal to sixty percent of his monthly earnings in the event that he became disabled. Doroshow chose to participate in the plan, and began receiving long term disability coverage as of July 1, 2006.

CVS funded this disability insurance plan via a group insurance policy it purchased from Hartford Life and Accident Insurance Company ("Hartford"). Like most insurance policies, the Hartford policy provided coverage to participants pursuant to certain limitations. One of those limitations involved pre-exiting conditions. The plan did not provide coverage for "any loss caused by, contributed to, or resulting from . . . a *Pre-existing Condition*[.]" (Def.'s Rep. Admin. [hereinafter "Admin. R."] at HLI0012.) The policy defined pre-existing condition as follows:

> ***Pre-existing Condition*** means a condition for which medical treatment or advice was rendered, prescribed or recommended within 12 months (3 months for exempt employees) prior to *Your* effective date of insurance. A condition shall no longer be considered pre-existing if it causes *Disability* which begins after *You* have been insured under the Policy for a period of 12 months.

(Admin. R. at HLI0013.) Additionally, under the terms of the contract, CVS "delegated sole discretionary authority to Hartford . . . to determine [participant's] eligibility for benefits and to interpret the terms and provisions of the plan and any policy issued in connection with it." (Admin. R. at HLI0024.)

Doroshow was diagnosed with Amyotropic Lateral Sclerosis ("ALS") on March 15, 2007, and applied for long-term disability benefits under the above described disability insurance plan on March 16, 2007. Thereafter, Doroshow left his job on a medical leave of absence on March 29, 2007. Hartford received the claim on August 3, 2007, and after reviewing the medical information contained therein, denied Doroshow's claim on August 30, 2007. Hartford sent Doroshow a letter explaining its reason for the denial. That letter stated:

> Our review of all of the medical information in your claim file shows that you are claiming benefits because of symptoms related to motor neuron disease (MND), which includes amyotrophic lateral sclerosis (ALS). The medical records obtained from the office of Dr. Goldstein indicate that you were treated for this condition on 05/16/2006. ALS was discussed in this OV, likely due to the type of symptoms you were experiencing and the family history of this disease. Intermittent workup and follow up continued for your reported symptoms until definitive diagnosis was reached in March 2007. You were provided advice related to the possibility of an ALS diagnosis on 05/16/2006, and the symptoms were certainly a precursor to the eventual diagnosis of ALS. This treatment

> date falls within the 3 month period that ends before your effective date of LTD coverage. This information shows that your condition was Pre-existing.

(Admin. R. at HLI0090.) Hartford determined that Doroshow was subject to the pre-existing condition exclusion, and denied his claim.

The medical records that Hartford referenced in its letter were from Doroshow's primary physician, Arnold Goldstein, M.D. In particular, Hartford relied on Dr. Goldstein's office notes following his treatment of Doroshow on May 16, 2006. In those notes, he wrote:

> ASSESSMENT:
>
> 1. CVA - lost 20 pounds. Working full time. Some residual weakness on the right side. Exercising using recumbent bike.
> 2. Motor neuron disease. Lumbosacral plexitis is the most recent diagnosis. Was not felt to be ALS.
> 3. Hypertension. Blood pressure has been stable. He takes it at work.
> 4. Laboratory. Cholesterol is 132, triglycerides are 94, HDL is 383 and LDL is 75.
> 5. MRI showed resorption of hemorrhage in the left basal ganglia. Still waiting for disability.

(Admin. R. at HLI0057.) At the time of this visit, Dr. Goldstein thought that Doroshow had motor neuron disease, but did not feel that it was ALS. Based on this information, Hartford determined that Dr. Goldstein had rendered advice pertaining to ALS, the disease

upon which Doroshow based his application for long-term benefits.

The medical records before Hartford pointed to also included evidence that Doroshow had received advice and endured testing related to ALS during the two years preceding the May 16, 2006 visit with Dr. Goldstein. On July 20, 2005, an electromyographic ("EMG") test was performed on Doroshow by Mark J. Brown, M.D., of the University of Pennsylvania, Department of Neurology. This evaluation was performed following complaints Doroshow made about leg weakness and a right foot drop problem. Dr. Brown wrote the following notes following the test:

> Impression
> 1. Chronic active degeneration of right leg, arm, paraspinal and bulbar muscles with near-normal nerve conduction studies. These are features of a motor neuron disease.
> 2. If the left Babinski sign is a consistent feature then he has the ALS form of motor nueron disease.
> 3. Mild small fiber-type sensory polyneuropathy of doubtful clinical significance.

(Admin. R. at HLI0072.) Dr. Brown recommended that Doroshow see an ALS specialist at the University of Pennsylvania for further evaluation and care.

On July 27, 2005, Doroshow visited Leo McCluskey, M.D., for a neurologic consultation. In the notes from that examination, Dr. McCluskey wrote, "Doroshow demonstrates evidence of a lower motor neuron process affecting his right leg[,]" and also that "[h]e has no

upper motor neuron signs." (Admin. R. at HLI0116.) Dr. McCluskey felt that "[t]hese are features that do not support the diagnosis of amyotropic lateral sclerosis [ALS] or a progressive motor neuron disorder[,]" and he thought that "lumbosacral plexopathy[1] should at least be considered in this situation." (Id.) Dr. McCluskey continued to treat Doroshow for motor neuron disease during the period between April 1, 2006, and June 30, 2006, and he was the doctor who conclusively diagnosed Doroshow with ALS on May 15, 2007.

After his claim for long term disability benefits was denied, Doroshow retained legal counsel, and appealed Hartford's decision via the insurer's administrative procedure. On December 13, 2007, Hartford upheld its initial decision denying Doroshow's claim on the basis of ineligibility under the pre-existing condition exclusion. On January 15, 2008, Doroshow filed an action in this Court pursuant to 29 U.S.C. § 1132(a)(1)(B) in which he claims that Hartford made its decision in an arbitrary and capricious manner. On March 30, 2008, Doroshow filed a Motion for Summary Judgment. Hartford filed a Motion for the same on April 7, 2008, and submitted a copy of the administrative record it used in reviewing the claim. Responses to these Motion have been filed, and this Court will address the arguments advanced by these Motions.

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[1] Plexopathy in this sense is a disease or disorder of an interlacing network of nerves. See J. E. Schmidt, M.D., Attorneys' Dictionary of Medicine P-296 (2007) (definitions of "plexopathy" and "plexus").

II. STANDARD OF REVIEW

Summary judgment is proper and "should be rendered if the pleadings, the discovery and disclosure materials on file, and any affidavits show that there is no genuine issue as to any material fact and that the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c); see Hines v. Consol. Rail Corp., 926 F.2d 262, 267 (3d Cir. 1991). In the absence of any material factual disputes, summary judgment must be granted against "a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." Celotex Corp. v. Catrett, 477 U.S. 317, 322 (1986).

On a motion for summary judgment, the moving party bears the initial burden of identifying those portions of the record which it believes demonstrate the absence of material factual disputes. Id. at 323. The non-moving party must respond with facts of record that contradict the facts identified by the movant and may not rest on mere denials. Id. at 321 n. 3. Where cross-motions for summary judgment have been presented, the Court must consider each motion individually. Reinert v. Giorgio Foods, Inc., 15 F. Supp. 2d 589, 593 (E.D. Pa. 1998). Each side bears the burden of establishing a lack of genuine issues of material fact, and showing that it is entitled to judgment as a matter of law. Id. at 593-94. "[S]ummary judgment should be granted where the evidence is such that it would require a directed verdict for the moving party[.]" Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 251 (1986).

III. DISCUSSION

The question before this Court is whether Hartford, as administrator of a benefits plan governed by ERISA, interpreted and applied the terms of the disability insurance plan in a reasonable manner, and whether its decision to deny Doroshow's claim under the pre-existing condition exclusion was supported by substantial evidence. There are no material factual disputes in this matter, rather both parties argue in their respective Motions that they are entitled to judgment as a matter of law. When addressing claims that an administrator made a benefits determination in violation of ERISA, this Court must first ascertain the appropriate standard of review to apply when conducting its review. After ascertaining the proper level of scrutiny, the Court then determines whether the administrator's decision was arbitrary or capricious.

ERISA does not specify the standard of review that a trial court should apply in actions pursuant to 29 U.S.C. § 1132(a)(1)(B). Thus, the analysis must begin with the Supreme Court's seminal decision in Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101 (1989). In Firestone, the Supreme Court held that "a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." Id. at 115. When the administrator has discretionary authority, any decisions made pursuant to that discretionary authority should be reviewed under an abuse of discretion standard, also known as an arbitrary and capricious standard. The Supreme Court

then added that when reviewing a decision under the arbitrary and capricious standard, "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" Id.

The various appeals courts have interpreted the "weighed as a factor" language to mean that the deference afforded the administrator under the abuse of discretion standard must be adjusted in relation to the presence and severity of conflicts. The Third Circuit has adopted a sliding scale approach to address the issue of conflicts on the part of the administrator, and how they affect the deference the courts must afford. See Pinto v. Reliance Std. Life Ins. Co., 214 F.3d 377, 392 (3d Cir. 2000). "This approach grants the administrator deference in accordance with the level of conflict." Post v. Hartford Ins. Co., 501 F.3d 154, 161 (3d Cir. 2007). "Thus, if the level of conflict is slight, most of the administrator's deference remains intact, and the court applies something similar to traditional arbitrary and capricious review; conversely, if the level of conflict is high, then most of its discretion is stripped away." Id.

Analysis under this sliding scale approach considers both structural and procedural factors. "The structural inquiry focuses on the financial incentives created by the way the plan is organized, whereas the procedural inquiry focuses on how the administrator treated the particular claimant." Post, 501 F.3d at 162. In regard to structural concerns, "[t]he court may take into account the sophistication of the parties, the information accessible to the parties, . . . the exact financial arrangement between the insurer and the

company," and the current financial status of the fiduciary to determine the deference that should be accorded to the administrator. Pinto, 214 F.2d at 392. When structural factors are present, the deference this Court must afford to the administrator's decision will be decreased.

Regarding procedural concerns, a district court must "look not only at the result—whether it is supported by reason—but at the process by which the result was achieved." Pinto, 214 F.3d at 393. The Third Circuit has identified numerous procedural irregularities that create concern for the courts. These include reversal of position without additional medical evidence, self-serving selectivity in the use and interpretation of physicians' reports, disregarding staff recommendations that benefits be awarded, and requesting a medical examination when all of the evidence indicates disability. Post, 501 F.2d at 164-65 (citing Kosiba v. Merck & Co., 384 F.3d 58, 67 (3d. Cir. 2004)). Similarly, when procedural factors are present, the deference afforded an administrator's decision is lower than under ordinary arbitrary and capricious review.

In the present action, this Court must determine how much authority Hartford was given under the terms of its insurance agreement with CVS. Hartford had sole discretionary authority to determine eligibility in the CVS disability insurance plan. The policy states that "[t]he plan administrator has delegated sole discretionary authority to Hartford Life and Accident Insurance Company to determine Your eligibility for benefits and to interpret the terms and provisions of the plan[.]" (Admin. R. at HLI0024.) Given that Hartford had sole discretion to administer

benefits, under the test established in Firestone, this action is subject to arbitrary and capricious review. Therefore, this Court must next assess whether structural or procedural conflicts exist, and determine the degree to which those conflicts will decrease the level of deference afforded to Hartford's decision.

One structural conflict stands out in this case. That conflict involves Hartford's dual role in funding the disability plan, and being solely responsible for determining eligibility under the plan. This financial arrangement is one that has long been of great concern to the Third Circuit in ERISA cases. The Third Circuit has repeatedly held that benefits plans administered and funded by outside insurers raise particular concern, and present a conflict that gives rise to heightened scrutiny all by itself. "[A]n insurance company [that] both funds and administers benefits, . . . is generally acting under a conflict that warrants a heightened form of the arbitrary and capricious standard of review." Pinto, 214 F.3d at 378. A recent decision of the Third Circuit held that this structural conflict "require[s] at least moderately heightened review." Post, 501 F.3d at 166. In light of this precedent, heightened arbitrary and capricious review will be applied in this action. Moreover, Hartford concedes in its brief that this Court must apply this standard of review, and Doroshow has not raised any objection in his response.

Regarding procedural factors, Doroshow claims that Hartford's reliance on the May 16, 2006, office notes of Dr. Goldstein is an anomaly that requires an even more searching review by this Court than that required under the moderately heightened standard. Doroshow is concerned that Hartford chose not to

procure an independent medical evaluation. The Court assumes that Doroshow, while not specifically stating so, is arguing that Hartford's reliance on Dr. Goldstein's notes evidences a self-serving selectivity in the interpretation and use of a physicians' report that this Court must guard against. This Court disagrees. Dr. Goldstein was Doroshow's primary care physician. As such, Hartford's decision to rely on his opinions does not appear to be self-serving since Hartford had no control over the content of these records. This Court would be concerned if the insurer relied exclusively on the report of a doctor it hired, but that is not the case here. Furthermore, the opinions expressed in these records are in accord with the opinions contained in the other notes compromising the administrative record. Finally, this Court notes that the record was replete with the notes of various medical experts in the field of motor neuron disease, and Hartford's decision not to obtain yet another expert's opinion does not raise the suspicions of this Court. Doroshow has not produced any evidence of procedural anomalies that require this Court to further decrease the deference it must afford Hartford's decision beyond that required under the moderately heightened arbitrary and capricious standard.

"Under the arbitrary and capricious standard, an administrator's decision will only be overturned if it is without reason, unsupported by substantial evidence or erroneous as a matter of law[,]" and "the court is not free to substitute its own judgment for that of the defendants in determining eligibility for plan benefits." Pinto, 214 F.2d at 387. A heightened arbitrary and capricious standard requires that the Court work from this baseline, while keeping in mind that its review should be "deferential, but not absolutely deferential"

to the administrator. Id. at 393. A moderately heightened arbitrary and capricious review affords less deference than the merely heightened level of arbitrary and capricious review. However, this Court cannot approach de novo review, which the Supreme Court has articulated is inappropriate in this situation. See Firestone, 489 U.S. at 115. With the above considerations in mind, this Court will now address the question of whether Hartford's decision that Doroshow was ineligible under the disability insurance plan is reasonable in light of the contract language, and whether that decision is supported by substantial evidence.

The language at issue in this action is the definition of "pre-existing condition" contained in the insurance contract between CVS and Hartford. The contract defines that phrase as "a condition for which medical treatment or advice was rendered, prescribed or recommended within 12 months (3 months for exempt employees) prior to *Your* effective date of insurance." (Admin. R. at HLI0013). At the root of the parties' dispute is Hartford's interpretation of the word "advice." The contract does not specifically define advice, so this Court must apply the ordinary meaning associated with this word. The dictionary defines advice as "an opinion or recommendation offered as a guide to action." The Random House College Dictionary 20 (Laurence Urdang et al. eds., 1973). This Court must determine if it was reasonable for Hartford to interpret the office notes of Dr. Goldstein as rendering advice regarding ALS.

Hartford argues that summary judgement is appropriate because the medical evidence in the administrative record clearly shows that Doroshow

received advice for ALS during the three months prior to his effective date of coverage. Hartford advances the May 16, 2006 office notes from Dr. Goldstein as proof of this fact. Dr. Goldstein stated that Doroshow had "Motor neuron disease. Lumbosacral plexitis is the most recent diagnosis. Was not felt to be ALS." (Admin. R. at HLI0057.) Hartford argues that ruling out a disease constitutes rendering advice. Thus, according to Hartford, advice was rendered to Doroshow relating to ALS prior to his effective date of coverage, which justifies the denial pursuant to the pre-existing condition exclusion.

This Court finds that Hartford was reasonable in determining that Dr. Goldstein rendered advice regarding ALS during Doroshow's office visit on May 16, 2006. By stating his opinion that the motor neuron disease afflicting his patient was not ALS but rather lumbosacral plexitis, Dr. Goldstein rendered an opinion about ALS during the three months prior to the effective date of coverage. Advice is a broader concept than treatment, and a doctor's conclusion that a patient is not suffering from a certain condition constitutes an opinion or recommendation offered as a guide to action. Ruling out ALS meant that Dr. Goldstein would treat Doroshow's motor neuron disease differently than he might of had it been ALS. Dr. Goldstein rendered an opinion that dictated the course of action he would take in treating Doroshow, and that opinion constitutes advice under a reasonable reading of the contract. Consequently, Hartford was reasonable in interpreting these office notes as advice pertaining to ALS, and its determination that Doroshow is ineligible for benefits under the plan due to the pre-existing condition exclusion should be afforded deference.

The record also showed that Doroshow had received advice regarding ALS on numerous other occasions since 2005. Dr. Brown noted in that year that an EMG performed on Doroshow showed "[c]hronic active degeneration of right leg, arm, paraspinal and bulbar muscles with near-normal nerve conduction studies. These are features of a motor neuron disease." (Admin. at HLI0072) Furthermore, he opined that "[i]f the left Babinski sign is a consistent feature then he has the ALS form of motor neuron disease." (Id.) Dr. Brown recommended that Doroshow see an ALS specialist. That specialist, Dr. McCluskey, noted in 2005 that Doroshow showed evidence of a lower motor neuron problem, but at the time did not exhibit signs of an upper motor neuron problem, which is a indication of ALS.[2] Dr. McCluskey opined that Doroshow's symptoms did not support an ALS diagnosis in 2005. (Admin. R. at IILI0116.) Thus, Doroshow had received many opinions about ALS. The disease was considered by all three doctors who examined him. Hartford's

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[2] "Amyotrophic lateral sclerosis (ALS) is the most common form of progressive motor neuron disease." Anthony S. Fauci, M.D., et. al., Harrison's Principles of Internal Medicine 2572 (17th ed. 2008). "Although at its onset ALS may involve selective loss of functions of only upper or lower motor neurons, it ultimately causes progressive loss of both categories of motor neurons. Indeed, in the absence of clear involvement of both motor neuron types, the diagnosis of ALS is questionable." Id. The World Federation of Neurology has established guidelines for diagnosing ALS. "The disorder is ranked as 'definite' when three or four of the following are involved: bulbar, cervical, thoracic, and lumbosacral motor neurons." Id. at 2573. "When two sites are involved, the diagnosis is 'probable,' and when only one site is implicated, the diagnosis is 'possible.'" Id. When a patient exhibits signs of a motor neuron problem, ALS is routinely considered as a possible condition by members of the medical community.

determination that Doroshow received advice pertaining to ALS during the three months prior to his effective date of coverage is therefore reasonable, and is supported by substantial evidence in the record.

Doroshow's contention that no advice was rendered to him regarding ALS has no merit in light of the above discussion. Doroshow bases his argument on the decision in Ceccanecchio v. Continental Cas. Co., 50 F. App'x 66 (3d. Cir. 2002). However, that case is distinguishable from the present action. The plaintiff in that case visited her doctor for a routine gynecological exam, prior to her effective date of coverage, and during that exam indicated to her doctor that she was experiencing urinary frequency and urgency. Id. at 67. Her doctor ordered a urinalysis, and recommended that she see a urologist if the results were negative. Id. The results came back negative, and the patient then visited with a urologist after she was covered under her insurance plan. Id. at 68. The urologist ultimately diagnosed with an interstitial cystitis. Id. The insurance company denied her claim for disability benefits pursuant to a pre-existing condition clause.

The Third Circuit found that the decision in Ceccanechio was arbitrary and capricious because the plaintiff's symptoms were non-specific during the look back period, and the insurer had no medical evidence in support of its contention that she had been treated for interstitial cystitis during that time. That insurer had argued that because a primary symptom of interstitial cystitis is frequent urination, it was self-evident that she had the condition when the urinalysis was ordered, which meant that she received treatment for that condition. Id. at 71. The plaintiff

showed that no medical opinion linked her symptoms with interstitial cystitis, and her symptoms were non-specific and indicative of a large range of diseases. Id. In finding that the insurer was not entitled to deference, the Third Circuit noted that there is a difference between a suspected condition without a confirmatory diagnosis, and misdiagnosis or an unsuspected condition manifesting non-specific symptoms. Id. at 72-73. Since interstitial cystitis was an unsuspected condition, the Third Circuit held that it could not constitute a pre-existing condition. Id.

Doroshow contends that his situation is similar to the plaintiff in Ceccanecchio in that his ALS was an unsuspected condition manifesting non-specific symptoms. His argument is incorrect. Doroshow was known to suffer from a motor neuron disease during the look back period, and ALS was specifically considered during his visit with Dr. Goldstein on May 16, 2006. Doroshow was also not misdiagnosed. He was initially diagnosed with a motor neuron disease, and in March 2007, he was conclusively diagnosed with ALS, the most common form of motor neuron disease. While Doroshow's condition was not labeled ALS, that disease was always a consideration for his doctors, unlike in Ceccanechio where doctors never suspected the condition upon which a disability claim was made. Doroshow has not shown that Hartford's decision was arbitrary and capricious. Consequently, his Motion is denied. Hartford has shown that it is entitled to summary judgment, thus its Motion will be granted.

An appropriate Order follows.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

CIVIL ACTION No. 08-259

[Filed May 30, 2008]

JAY DOROSHOW,
Plaintiff,

v.

HARTFORD LIFE AND ACCIDENT INSURANCE CO. and CVS CORPORATION LONG TERM DISABILITY INCOME INSURANCE PLAN
Defendants.

ORDER

AND NOW, this 30th day of May, 2008, upon consideration of the Motion for Summary Judgment filed by Plaintiff Jay Doroshow (Doc. No. 7), the Motion for Summary Judgment filed by Defendant Hartford Life and Accident Insurance Co. (Doc. No. 10), and the responses thereto, it is hereby **ORDERED** that:

1. Plaintiff Jay Doroshow's Motion for Summary Judgment is **DENIED**; and

2. Defendant Hartford Life and Accident Insurance Company's Motion for Summary Judgment is **GRANTED**.

BY THE COURT

/s/ Robert F. Kelly
ROBERT F. KELLY
SENIOR JUDGE

APPENDIX C

UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

No. 08-2836

[Filed August 25, 2009]

JAY DOROSHOW,

Appellant.

v.

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Before: SCIRICA, Chief Judge, McKEE, RENDELL, BARRY, AMBRO, FUENTES, SMITH, FISHER, CHAGARES, JORDAN, HARDIMAN and ROTH*, Circuit Judges

ORDER

The petition for panel rehearing and rehearing en banc filed by the appellant in the above-entitled case having been submitted to the judges who participated in the decision of this Court and to all the other

* Judge Roth's vote is limited to panel rehearing only.

available circuit judges of the circuit in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of the circuit in regular active service not having voted for rehearing by the court en banc, the petition for rehearing is denied. Judges Rendell, McKee, and Ambro voted for rehearing.

By the Court,
/s/ JANE R. ROTH
Circuit Judge

Dated: August 25, 2009
smw/cc: Scott I. Fegley, Esq.
Brian P. Downey, Esq.
Stacey I. Gregory, Esq.

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Supreme Court, U.S.
FILED
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OFFICE OF THE CLERK

No. 09-474

IN THE

Supreme Court of the United States

JAY DOROSHOW,

Petitioner,

v.

HARTFORD LIFE AND ACCIDENT INSURANCE CO.,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF IN OPPOSITION

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QUESTION PRESENTED

Whether the court of appeals correctly applied the "deferential standard" of *Metropolitan Life Insurance Co.* v. *Glenn*, 128 S. Ct. 2343 (2008) to conclude that there was substantial evidence in support of a claim administrator's determination that a doctor's tentative assessment about a condition—"Was not thought to be [Amyotrophic Lateral Sclerosis]"—constituted advice for that condition, in light of the insured's family history, medical record, commonality between ALS and insured's diagnosed condition of motor neuron disease, and progressive nature of ALS, thus triggering a pre-existing condition exclusion under a disability insurance policy.

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IN THE

Supreme Court of the United States

No. 09-474

JAY DOROSHOW,

Petitioner,

v.

HARTFORD LIFE AND ACCIDENT INSURANCE CO.,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF IN OPPOSITION

STATEMENT

Petitioner Jay Doroshow was a participant in an employee welfare plan that provided long-term disability benefits. The plan was governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §§ 1001 *et seq.*, and funded by an insurance policy administered by Hartford Life and Accident Insurance Company. The policy excluded coverage for any loss resulting from a pre-existing condition, which in turn was defined as "a condition for which medical treatment or advice was rendered, prescribed, or recommended" within a three-month look-back period before the policy's effective date of coverage. Pet. 3 (internal quotation marks omitted).

During the look-back period, petitioner was diagnosed by his primary physician, Dr. Arnold Goldstein, as having motor neuron disease (MND), which was described at the time as lumbosacral plexitis and "[w]as not felt to be ALS [Amyotrophic Lateral Sclerosis]." *Doroshow* v. *Hartford Life & Accident Ins. Co.*, No. 2:08-cv-00259-RK, Dkt. No. 9, at HLI0057 (E.D. Pa. Apr. 7, 2008). Even before the look-back period, petitioner had received advice and testing related to ALS. For instance, one doctor found petitioner to have "[c]hronic active denervation of right leg, arm, paraspinal and bulbar muscles," which were "features of a motor neuron disease." *Id.* at HLI0072. This doctor observed that "[i]f the left Babinski sign is a consistent feature, then [petitioner] has the ALS form of motor neuron disease," and recommended that petitioner see an ALS specialist. *Id.* The ALS specialist found evidence of a lower motor neuron problem, but no signs of an upper motor neuron problem, and concluded that the former symptoms at the time did not support an ALS diagnosis. *Id.* at HLI0116. Both doctors noted petitioner's family history of ALS. *Id.* at HLI0071, 116.

After the effective date of the policy, petitioner was conclusively diagnosed with ALS and applied for long-term disability benefits. Hartford denied petitioner's claim based on the pre-existing condition exclusion. In its letter to petitioner, Hartford stated:

> Our review of all the medical information in your claim file shows that you are claiming benefits because of symptoms related to motor neuron disease (MND), which includes amyotrophic lateral sclerosis (ALS). The medical records obtained from the office of Dr. Goldstein indicate that you were treated for this condition [during the look-back period]. ALS was

> discussed in this [office visit], likely due to the type of symptoms you were experiencing and the family history of this disease. Intermittent workup and follow up continued for your reported symptoms until definitive diagnosis [during the policy's period of coverage.]

Pet. App. 21a.

Reviewing the benefits decision for abuse of discretion, the district court found that there was substantial evidence showing that petitioner received advice for ALS during the look-back period. The court noted that "[a]dvice is a broader concept than treatment, and a doctor's conclusion that a patient is not suffering from a certain condition constitutes an opinion or recommendation offered as a guide to action," a dictionary meaning of "advice" adopted by the court and uncontested by the parties. Pet. App. 32a. Moreover, the court found that ALS "was considered by all ... doctors who examined" petitioner before the effective date of coverage. Pet. App. 33a. Based on a medical treatise, the court observed that ALS "'is the most common form of progressive motor neuron disease'" and when lumbosacral motor neurons are affected, "diagnosis [of ALS] is 'possible.'" Pet. App. 33a n.2 (quoting Anthony S. Fauci, M.D., et al., *Harrison's Principles of Internal Medicine* 2572, 2573 (17th ed. 2008)). Finally, the Court noted that when "a patient exhibits signs of a motor neuron problem, ALS is routinely considered as a possible condition by members of the medical community." *Id.*

The court of appeals affirmed the district court's judgment, finding "Dr. Goldstein's notes related to ALS particularly compelling in the broader context of Doroshow's entire medical history." Pet. App. 10a.

Furthermore, the court observed that due to the "progressive nature of the disease, it is not surprising that, when Doroshow first began exhibiting symptoms, the doctors did not conclusively determine that he had ALS, but more generally said only that he had a form of motor neuron disease." Pet. App. 11a. Thus, based on petitioner's "family history of ALS and his medical records," the court concluded "that it is clear that Doroshow sought advice for ALS when he visited Dr. Goldstein during the look-back period." Pet. App. 13a. Petitioner's request for en banc review was denied by the Third Circuit, with eight out of eleven active judges not voting for rehearing (Pet. App. 38a-39a), rather than six as alleged by petitioner (Pet. 1).

REASONS FOR DENYING THE WRIT

I. THERE IS NO IMPORTANT QUESTION OF FEDERAL LAW RAISED BY PETITIONER

Petitioner's argument reduces to a request that this Court correct the Third Circuit's application of this Court's decision in *Metropolitan Life Ins. Co.* v. *Glenn*, 128 S. Ct. 2343 (2008) to the particularized facts of this case, a submission that does not warrant this Court's review. Indeed, petitioner acknowledges that just last Term, *Glenn* restated the legal standard to be applied by lower courts reviewing claim administrators' benefit decisions under ERISA. Pet. 5. Petitioner neither challenges the legal standard of review nor argues that the Third Circuit acted in contravention of any other Supreme Court precedent. Because he challenges only the application of the *Glenn* standard to the particularized facts of his case, there is no need for further guidance from the Court on the question raised by petitioner.

In *Glenn*, the Court confirmed the previous standard of review established in *Firestone Tire & Rubber*

Co. v. *Bruch*, 489 U.S. 101 (1989), under which courts apply a deferential standard for abuse of discretion in cases where, as here, an insurance plan grants an administrator discretionary authority to determine eligibility for benefits. The Court also clarified that a claim administrator, that both determines eligibility and pays benefits, has a structural conflict of interest that does not change the abuse of discretion standard. Instead, the Court held that such structural conflict should be weighed as one factor in determining whether there was an abuse of discretion. *See* 128 S. Ct. at 2346. Finally, the Court emphasized the complex and fact-intensive nature entailed in judicial review of benefits decisions:

> Benefits decisions arise in too many contexts, concern too many circumstances, and can relate in too many different ways to conflicts—which themselves vary in kind and in degree of seriousness—for us to come up with a one-size-fits-all procedural system that is likely to promote fair and accurate review.

Id. at 2351.

Petitioner seeks to turn a complex factual question, contingent on the particularized context of each case, into a bright-line legal question. Pet. 5 ("[P]etitioner contends that it is *never* reasonable to construe a negative diagnosis as advice." (emphasis added)). Petitioner's arguments aim to relitigate the application of the abuse of discretion standard articulated in *Glenn* that was fully considered thrice below by the district court, a court of appeals panel, and the full en banc court of the Third Circuit, in light of petitioner's family history, medical record, the commonality between ALS and MND, and the progressive nature of ALS.

Moreover, the Question Presented embeds a new argument not made in the record of the administrative proceeding or argued in the district court—that the physician's note cannot be "advice" because it was not offered to petitioner. Pet. 6, 11-12. Indeed, although petitioner challenged in writing the denial of benefits as a result of the physician's note, he did so not for the reason that the advice recorded in the note was never provided to him, but rather on the asserted basis that the physician believed that ALS "was not likely" and thus petitioner's later diagnosis could not be applied "retroactively." *Doroshow* v. *Hartford Life & Accident Ins. Co.*, No. 2:08-cv-00259-RK, Dkt. No. 9, at HLI0048-49 (E.D. Pa. Apr. 7, 2008). Since petitioner raised this issue for the first time on appeal, the court of appeals did not address it, evidently—and correctly—deeming the argument waived in light of his failure to preserve it in the district court. *See Webb* v. *City of Phila.*, 562 F.3d 256, 263 (3d Cir. 2009) (Scirica, C.J.) ("Generally, failure to raise an issue in the District Court results in its waiver on appeal." (internal quotation marks omitted) (citing cases)). Having waived that argument below, petitioner raises this issue in this Court in an improper posture.

Finally, petitioner profoundly mischaracterizes the district court's opinion in *Cohen* v. *Metropolitan Life Insurance Co.*, 485 F. Supp. 2d 339 (S.D.N.Y. 2007), which involved significantly different facts from the circumstances here and does not stand for the holdings contended by petitioner. Pet. 6-10. In *Cohen*, the court found the claim administrator's decision that "receiving *any* medical care or treatment during a look-back period disqualified a participant from receiving disability benefits" as "fundamentally unreasonable" since the insurance plan clearly stated that such medical care or

treatment must relate to the sickness that gave rise to the claimed disability. 485 F. Supp. 2d at 349-350 (emphasis in original). In addition, the court noted that the administrator "merely identifie[d] a degree of facial similarity between certain of the symptoms [such as tiredness] prior to and during the look-back period and those ... cited many months later as preventing [insured] from working," namely, Chronic Fatigue Syndrome (CFS). *Id.* at 350. The failure to associate a generic symptom, such as tiredness, with CFS is not analogous to the express acknowledgment of the possibility of ALS along the progressive spectrum of MND, with which petitioner was specifically diagnosed during the look-back period. In *Cohen*, there also was no family history of the disease as was the case with petitioner.

In addition, the *Cohen* court found significant procedural irregularities underlying the denial decision, such as the claim administrator's "failure to provide notice to [the insured] of its consideration of materials [obtained from insured's doctors] in addition to those disclosed following its initial denial" and its subsequent refusal to consider insured's submissions in response to these additional materials. 485 F. Supp. 2d at 353. Such "failure to comply with ERISA's full and fair review mandate," the court concluded, "rendered [the] decision arbitrary and capricious." *Id.* Here, in contrast, the district court found that "Doroshow ha[d] not produced any evidence of procedural anomalies." Pet. App. 30a.

Rather than holding, as claimed by petitioner, "that the insurer's preexisting condition did not apply as a matter of law" (Pet. 7), the *Cohen* court based its decision on the "entire administrative record" involving the weighing of a complex set of particularized facts listed

above, 485 F. Supp. 2d at 354. Thus, petitioner has failed to demonstrate that lower courts would have reached different conclusions even if presented with the same facts.

The only potential relevance of *Cohen* is to demonstrate, as petitioner concedes, that the particularized set of facts raised by this case is of "first impression" (Pet. 2, 6), and thus has not yet been fully developed in the lower courts. *See* Eugene Gressman et al, *Supreme Court Practice* 504 (9th ed. 2007). This Court's scarce resources ought not be burdened to provide guidance on the application of *Glenn* to these specific facts, particularly where *no* other court has yet addressed this issue in the context of progressive, hereditary diseases such as ALS. The issue raised by petitioner would thus benefit from further percolation as more courts review application of pre-existing condition clauses in ERISA plans in the context of advice regarding a family of related, progressive diseases. Thus, there is no important question of federal law for the Court to consider.

II. THERE IS NO CONFLICT BETWEEN THE THIRD CIRCUIT DECISION AND ANY DECISION OF THIS COURT, OTHER CIRCUIT COURTS, OR PRIOR THIRD CIRCUIT CASES

Petitioner has failed to identify a single decision of this Court or other circuit courts, with which the Third Circuit decision is purported to be in conflict. Indeed, there is none. That fact alone justifies denial of the petition, as there is no allegation that the Third Circuit's decision will produce any conflict with other decisions that would result in confusion or differing implementation of ERISA in varying jurisdictions across the country.

Although petitioner attempts to portray a conflict between the court of appeals' opinion here and two prior decisions in the Third Circuit (Pet. 13-19), there is

no such conflict. Even if there were such conflict, it would not be appropriate for this Court's review. As this Court has long held, alleged conflicts within a circuit court are supposed to be resolved internally in the circuit by rehearing en banc. *See* Gressman et al., *Supreme Court Practice* 503. Here, the Third Circuit provided such review and categorically rejected petitioner's claims, with all but three of eleven judges of the full active court not voting for rehearing en banc.

As the court of appeals panel held, there is no conflict between its decision and prior Third Circuit decisions. The panel pointed out that the two cases cited by petitioner—*McLeod* v. *Hartford Life & Accident Insurance Co.*, 372 F.3d 618 (3d Cir. 2004) (Becker, J.) and *Lawson* v. *Fortis Insurance Co.*, 301 F.3d 159 (3d Cir. 2002) (Alito, J.)—concerned a "misdiagnosis or an unsuspected condition manifesting non-specific symptoms," which thus did not trigger the pre-existing condition exclusion. Pet. App. 13a (internal quotation marks omitted). In *McCleod* and *Lawson*, the plaintiffs were treated for numbness and respiratory tract infection, respectively, but were not suspected to have, or diagnosed with, the multiple sclerosis and leukemia that subsequently caused their respective disabilities. In contrast, the Third Circuit held in this case that petitioner "had a suspected condition without a confirmatory diagnosis, which may appropriately be deemed a pre-existing condition." Pet. App. 13a (internal quotation marks omitted). Distinguishing a misdiagnosis or unsuspected condition from a suspected condition without a confirmatory diagnosis, the *Lawson* court noted:

> [In cases where] the claimants suspected a particular condition when they saw their physicians, it might make sense to say that the claimants had received advice or treatment

> "for" their respective conditions, although they had not been definitively diagnosed. In both instances, a particular condition was suspected; treatment, advice, or testing for that suspected condition was provided; and the pre-effective date treatment, advice, or testing turned out to be "for" the condition that was ultimately diagnosed.

301 F.3d at 165-66. *See also McLeod*, 372 F.3d at 629 (neither the insured nor the insured's doctors "either knew or suspected that the symptoms [insured] was experiencing were in any way connected" with the subsequent condition giving rise to the benefits claim).

The unpublished opinion in *Ceccanecchio* v. *Continental Casualty Co.*, 50 F. App'x 66 (3d Cir. 2002) provides no basis for this Court's review. Because the Third Circuit does not recognize unpublished decisions as precedential, Internal Operating Procedure Rule 5.7, the panel here did not address *Ceccanecchio*. *See Jamison* v. *Klem*, 544 F.3d 266, 278 n.11 (3d Cir. 2008) (McKee, J.) ("We have steadfastly attempted to discourage District Courts as well as attorneys from relying on nonprecedential opinions of this court."). In any event, the facts in *Ceccanecchio* are similar to *McLeod* and *Lawson*, and distinct from the case here, insofar as the insured underwent a routine gynecological exam, at which the doctor noted urinary frequency and urgency, and nocturia four times the previous year, but did not suspect or diagnose the severe case of interstitial cystitis that subsequently caused the insured's disability.

Finally, three different standards of review were applied in the three precedential Third Circuit decisions alleged to be in conflict by petitioner. *Lawson*, arising out of a breach of contract claim rather than a

claim under ERISA, was decided based on a *de novo* standard of review. *McLeod* used a heightened arbitrary and capricious standard of review. Here, the court of appeals applied the abuse of discretion standard of review confirmed by the Supreme Court in *Glenn*. Clearly, courts reviewing benefits determinations based on different standards of review applied to complex and particularized facts may reach different results. Indeed, the *McLeod* court observed that if a non-heightened standard of review applied to the facts before it, and the insurer had "provided a plausible reason for its interpretation, then perhaps the result [of the case] would be different." 372 F.3d at 624.

Thus, there is no conflict between the Third Circuit decision and any decision of this Court, other circuit courts, or prior Third Circuit cases.

CONCLUSION

For the foregoing reasons, the Petition for a Writ of Certiorari should be denied.

Respectfully submitted.

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